SC Department of Disabilities and Special Needs
Medication Error/Event Report

☐ ***Community*** ☐ ***Regional Center***

Provider Reporting Incident: _____ ***County:*** _____

☐**District I:** ☐Midlands ☐Piedmont ☐**District II:** ☐Coastal ☐Pee Dee

Residence of Consumer:	***Descriptive Location of Residence:***
☐*CRCF* ☐*CTH-I* ☐*CTH-II* ☐*ICF* ☐*SLP-I* ☐*SLP-II* ☐*Unit @ Regional Center*	*(Example: Smith CTH-I, Pee Dee Center)* _____
Location of Incident: ☐*CRCF* ☐*Day Program* ☐*CTH* ☐*ICF* ☐*SLP* ☐*Unit @ Regional Center*	***Descriptive Location of Incident:*** *(Indicate unit name in Regional Center, provider operated facility name, i.e., Sunrise CTH-II, enclave, work activity center* _____

Consumer: *First* _____ *Middle* _____ *Last* _____

DOB:	***Age:***	***Sex:***	***Date of Med Error:***	***Time of Med Error:***	***Date Error Found:***
/ / *MM/DD/YY*		☐*Male* ☐*Female*	/ /	: ☐*AM* ☐ *PM*	/ /

Name & Dose of Medications Involved:

What type of Med Error/Event occurred: (Mark all that Apply)

☐Wrong person given the medication
☐Wrong medication given
☐Wrong dosage given
☐Wrong route of administration
☐Wrong time
☐Medication given without an order
☐Transcription error
☐Medication not signed off on properly
☐Medication found
☐Medication not given by staff
☐Medication missing
☐Prescribed observation/Pre-treatment not followed as indicated on the Plan
☐"Near Miss" for a Med error
☐Person refused medication (Record attempts/methods)
☐Unsafe circumstances
☐Pharmacy Error-indirectly involving individual
☐Pharmacy Error-directly involving individual

What was the result of the Med Error/Event: (At the time the Report was completed)	***Prescriber Notified:*** ☐***Yes*** ☐***No***
☐No Error (Near Miss or Red Flag Event) ☐Error, No Reaction ☐Error, Reaction, No medical Rx required ☐Error, Reaction, Medical Rx required ***** ☐Error, Reaction, Death *****	When: _____ By Whom: _____ If no, explain: _____

Staff Suspected of Making the Error:

Events Leading to Med Error/Event:

Name of Prescriber:	***Name of Pharmacy:***	***Signature of Person Making Out Report/Date***

Signature of Supervising Nurse : ***Date:***	***Signature of Program Administrator :*** ***Date:***

****Requires the completion of Critical Incident Report per DDSN Directive 100-09-DD.***